"(b) (1) Premium approval. – No schedule of premiums for coverage for health care services, or any amendment to the schedule, shall be used in conjunction with any health care plan until a copy of the schedule or amendment has been filed with and approved by the Commissioner.

(2) Individual coverage. – Premiums shall be established in accordance with actuarial principles for various categories of enrollees. Premiums applicable to an enrollee shall not be individually determined based on the status of the enrollee's health. Premiums shall not be excessive, inadequate or unfairly discriminatory; and shall exhibit a reasonable relationship to the benefits provided by the evidence of coverage. The premiums or any premium revisions ~~to the premiums with respect to~~ for nongroup enrollee coverage shall be guaranteed, as to every enrollee covered under the same category of enrollee coverage, for a period of not less than 12 months. As an alternative to giving this guarantee for nongroup enrollee coverage, the premium or premium revisions may be made applicable to all similar ~~category~~ categories of enrollee coverage at one time if the health maintenance organization chooses to apply for the premium revision with respect to ~~such~~ the categories of coverages no more frequently than once in any 12-month period. The premium revision shall be applicable to all categories of nongroup enrollee coverage of the same type; provided that no premium revision may become effective for any category of enrollee coverage unless the HMO has given written notice of the premium revision to the enrollee 45 days before the effective date of the revision. The enrollee ~~thereafter~~ must then pay the revised premium in order to continue the contract in force. The Commissioner may adopt reasonable rules, after notice and hearing, to require the submittal of supporting data and such information as the Commissioner considers necessary to determine whether the rate revisions meet the standards in this subdivision. In adopting the rules under this subsection, the Commissioner may require identification of the types of rating methodologies used by filers and may also address standards for data in HMO rate filings for initial filings, filings by recently licensed HMOs, and rate revision filings; data requirements for service area expansion requests; policy reserves used in rating; incurred loss